Form **1095-B**
Department of the Treasury
Internal Revenue Service

Health Coverage

2015-000001-000000001

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2015

Information about Form 1095-B and its separate instructions is at www.irs.gov/form 1095b

Part I Responsible Individual

Lines 4-7: address shown below

1 JOHN DOE
2 Social Security Number (SSN):
3 Date of Birth (if SSN is not available): 01/01/2001

JOHN DOE
123 MAIN STREET
SPRINGFIELD, IL 62707

8 Origin of the Policy: **C**

9 Small Business Health Options (SHOP) Marketplace Identifier, if applicable

You are getting this form because the people listed below got minimum essential coverage through the Illinois Medicaid or All Kids program for the months listed below. Individuals listed will need to use this information for their 2015 federal income tax return. If there are some months with no minimum essential coverage from any source, individuals should see if they qualify for a health coverage exemption (go to www.healthcare.gov/taxes)

Part II Employer Sponsored Coverage

10 11 12 13 14 15

Part III Issuer or Other Coverage Provider (see instructions)

16 Illinois Healthcare and Family Services
17 EIN: 37-1320188
18 Phone Number: 1-800-843-6154
19 P.O. Box 19122
TTY: 1-800-447-6404
20 Springfield
21 IL
22 62794-9122

Part IV Covered Individuals

(a) Name of Covered Individuals	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage (if column d is blank)											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 JOHN DOE		01/01/2001		X	X	X	X								
24 JANE DOE	xxx-xx-1234		X												
25															
26															
27															
28															

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Part I. Responsible Individual, lines 1-9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN). For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

Caution! *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Other designated minimum essential coverage

TIP *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will be reported on a Form 1095-A rather than a Form 1095-B.*

Line 9. This line will be blank for 2015.

Part II. Employer-Sponsored Coverage, lines 10-15. This part will be completed by the insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. If your coverage is not insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, Line 16-22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.

Part IV. Covered Individuals, lines 23-28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in Column (c) only if an SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see part Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Spenddown Note If you received Medicaid for at least one month of the year through spenddown, you may apply for a hardship exemption from the individual shared responsibility payment for uncovered months. Fill out and send in an Application for a Hardship Exemption (Form 8965-Health Coverage Exemptions) found at **www.healthcare.gov/taxes.** For the Type of Hardship, choose "Other" and then write in: *"[person's first and last name] had 209(b) Medicaid coverage because he or she met the spenddown amount in at least one month during 2015. He or she got medical coverage for [enter the months in 2015 you had coverage whether or not you used it] and did not get coverage for [enter the months in 2015 you did not get coverage] because he or she did not meet spenddown."*

For the complete list of health coverage exemptions go to www.healthcare.gov/taxes and click on Form 8965.